HEALTHCARE ASSOCIATED INFECTIONS

Answers to Consultation Questions (Annex B)

1. Possibly, though they do not go far enough.
2. By asking them directly to participate in consultation events and in the training of healthcare professionals. Also lay members should be recruited from PPFs to accompany inspectors on visits: patients may see things that inspectors don't, and will often have personal experience of healthcare settings to inform their scrutiny.
3. It is fervently hoped that this will result in improvement.
4. No comment: we do not have the information, as members of the public.
5. Spot checks are the obvious answer: don't give advance notice of inspections.
6. We would be in favour of random, unannounced inspections, as well as risk-based.
7. Yes.
8. See comment below.
8. see below
9. see below

In para. 8 you say: 'The aim is to measure the things that matter to patients.'

Your paper does not mention one matter of serious concern to patients:

Doctors' handwashing on home visits. This is very difficult (if not impossible) to monitor, yet it is a matter of urgent concern, judging by anecdotal evidence. Recent events illustrate that many doctors making home visits do not wash their hands (or ask if they may), or even use alcohol gel. This can only be dealt with by improved GP training.

It needs to be said that patients are so grateful for home visits, which in the modern NHS are regarded as something of a luxury, that they are reluctant to challenge doctors or invite them to wash their hands.

Cleaning

Unfortunately hospitals with PFI contracts are unable to supervise cleaning on a ward basis, and cleaners are not part of the ward team (an arrangement that gives much greater job satisfaction and, we think, better service). Again, recent events show that cleaning, when not adequate (as in for instance the Royal Infirmary of Edinburgh), cannot be improved while supervision is not immediate. Recent experience has been of ward staff unable to deal with cleaning issues straight away, since management could not be contacted forthwith by the nursing staff: a patient was recently told to 'write in' (hardly a satisfactory answer to a bed-bound patient concerned about the cleanliness of her immediate surroundings). Carpeting in hospitals can be a source of infection, and thought should be given to this in any new build.

In the experience of our members, cleaning standards are not adequate in many healthcare settings. The fact that the Cabinet Secretary for Health and Wellbeing has announced that hospital cleaning is to be brought back in-house is most welcome: however, until contracts are

renegotiated an interim plan needs to be devised to check particularly thoroughly on premises with PFI contracts.

Involvement of PPFs (para 11)
It is suggested that peer reviewers and inspectors of cleaning standards etc. are recruited from PPFs, and that this is made a high priority. However, PPFs are not invariably fully functional, and the net should be spread more widely to include other members of the public, including patient groups meeting in hospitals.

Para 12 (d)
Once every three years for unannounced visits of the inspectorate is not nearly frequent enough. Surely annual visits should be the minimum time-frame.

Swabbing suspect areas
One of our members with healthcare experience draws attention to the practice that does not now seem to be common of ward sisters or other staff requesting Bacteriology to take swabs from suspect areas, reporting back their findings so that any adjustments to cleaning/procedures etc. could be made. We suggest that this more scientific approach will track bacteria before they cause a problem: there is a good deal that the eye cannot see.

Conclusion
The recommendations made in this document do not (in our opinion) go far enough. We have a very serious problem on our hands of healthcare-associated infection, and we need to go back to Semmelweis and Nightingale basics.

The move to allow only single rooms in new-build hospitals is not necessarily the answer. While we accept that this may to some extent cut down the rates of infection, and make any infection that does arise easier to manage, single rooms will not *of themselves* solve the problem. If the standard of cleaning is low in the hospital, it will be low whether the rooms are single or shared. (One particularly bad example of poor cleaning was observed by one of our members in a single room.)

Another point to bear in mind is that while staff up to and including nurses have to wear uniform, doctors do not, and we suggest that they should: the fact that doctors come into hospitals in their street clothes and do not wear uniforms must add to the rate of airborne infection.

Young lady doctors also should be asked to tie back long hair, and all staff should make sure that their nails are kept short. We are not happy either about the habit of young doctors to visit the canteen with their stethoscopes round their necks, and think that this must have hygiene implications. We suggest that stethoscopes should be sterilized (using an antiseptic wipe) between patients.

These are simple suggestions, but we think that they could make a difference.
Hospital Catering
A carer was recently shocked when a member of the catering staff in a hospital offered cake at tea-time to a patient, who was unable to see (owing to a recent stroke). Instead of using tongs to

take the cake from the plastic box on the trolley, she used her fingers, giving it to the relative by the bedside, who inevitably had to use her fingers to transfer it to the patient's plate. This procedure would be totally out of order in the most basic of commercial cafés. All staff need to be updated on food hygiene.

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